

# Schedule of Benefits

Employer: State of Maryland

ASA: 813929

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Schedule: 1A

Booklet Base: 1

For: Open Access Exclusive Provider Organization (EPO) Aetna Select Medical Plan

## Aetna Select Medical Plan

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<i>Lifetime Maximum Benefit per person</i>	Unlimited	Not applicable

### Copayment Maximum Out of Pocket

#### Individual Calendar Year Copayment Maximum Out of Pocket Limit:

- For **network** expenses: \$1,000

#### Family Copayment Limit:

- For **network** expenses: \$2,000

*The coinsurance listed in the Schedule below reflects the Plan Coinsurance. This is the amount the Plan pays. You are responsible for full payment of any non-covered expenses you incur.*

PLAN FEATURES	NETWORK	OUT OF NETWORK
<i>Preventive Care</i>		
<i>Routine Physical Exams</i>		
<i>Office Visits</i>	100% of the allowed benefit per visit.  No <b>copay</b> applies.	Not Covered

<i>Covered Persons through age 21: Maximum Age &amp; Visit Limits per Calendar Year</i>	Subject to any age and visit limits provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.  <i>For details, contact your <b>physician</b> log onto the Aetna website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID</i>	Not Covered
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	<i>card.</i>	
Covered Persons ages 22 but less than 65: Maximum Visits per Calendar Year	1 visit	Not Covered
Covered Persons age 65 and over: Maximum Visits per Calendar Year	1 visit	Not Covered.
<b>Preventive Care Immunizations</b>		
<i>Performed in a facility or <b>physician's office</b></i>	100% of the allowed benefit per visit.	Not Covered
	No <b>copay</b> applies.	
<b>Screening &amp; Counseling Services-Obesity, Misuse of Alcohol and/or Drugs &amp; Use of Tobacco Products</b>		
	100% of the allowed benefit per visit.	Not Covered
	No <b>copay</b> applies.	
<i>Obesity</i> Maximum Visits per Calendar Year (This maximum applies only to Covered Persons ages 22 & older.)	26 visits (however, of these only 10 visits will be allowed under the Plan for healthy diet counseling provided in connection with Hyperlipidemia (high cholesterol) and other known risk factors for cardiovascular and diet-related chronic disease)*	Not Covered.
<b>*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</b>		
<i>Misuse of Alcohol and/or Drugs</i> Maximum Visits per Calendar Year	5 visits *	Not Covered.
<b>*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</b>		
<i>Use of Tobacco Products</i> Maximum Visits per Calendar Year	8 visits *	Not Covered.
<b>*Note: In figuring the Maximum Visits, each session of up to 60 minutes is equal to one visit.</b>		
<b>Well Woman Preventive Visits</b>		
<b>Office Visits</b>	100% of the allowed benefit per visit	Not Covered
Maximum Visits per Calendar Year	1 visit	Not Covered

<b>Hearing Exam</b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Maximum exams per 36 month period	1 exam	Not Covered
Hearing Supply Maximum per 36 month period	Unlimited	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b>Routine Cancer Screenings</b>		

<b>Outpatient</b>	100% of the allowed benefit per visit	Not Covered
Maximums	<p>Subject to any age and visit limits provided for in the current recommendations of the United States Preventive Services Task Force and comprehensive guidelines supported by the Health Resources and Services Administration.</p> <p><i>For details, contact your <b>physician</b>, log onto the <b>Aetna</b> website <a href="http://www.aetna.com">www.aetna.com</a>, or call the number on the back of your ID card.</i></p>	Not Covered

<b>Prenatal Care Office Visits</b>	100% of the allowed benefit per visit	Not Covered
	No <b>copay</b> applies.	
<b>Important Note:</b> Refer to the Physician Services and Pregnancy Expenses sections of the Schedule of Benefits for more information on coverage levels for pregnancy expenses under this Plan, including other prenatal care, delivery and postnatal care office visits.		

<b>Comprehensive Lactation Support and Counseling Services</b>		
<b>Lactation Counseling Services</b>	100% of the allowed benefit per visit	Not Covered.
<i>Facility or Office Visits</i>	No <b>copay</b> applies.	

Lactation Counseling Services	6* visits per Calendar Year	Not Covered
Maximum Visits either in a group or individual setting		

**\*Important Note:** Visits in excess of the Lactation Counseling Services Maximum as shown above, are covered under the *Physician Services* office visit section of the *Schedule of Benefits*.

<b>Breast Pumps &amp; Supplies</b> (Through durable medical equipment supplier)	100% of the allowed benefit per item per birth.  No <b>copay</b> applies.	Not Covered
<b>Family Planning - Other</b>		
Voluntary Termination of Pregnancy Outpatient	100% of the allowed benefit per visit	Not Covered.
Voluntary Sterilization for Males		
Outpatient	100% of the allowed benefit per visit	Not Covered.
<b>Family Planning Services</b>		
Female Contraceptive Counseling Services Office Visits.	100% of the allowed benefit per visit	Not Covered.
Contraceptive Counseling Services - Maximum Visits either in a group or individual setting	2* visits per Calendar Year	Not Covered.
*Important Note: Visits in excess of the Contraceptive Counseling Services Maximum as shown above, are covered under the <i>Physician Services</i> office visit section of the <i>Schedule of Benefits</i> .		
<b>Family Planning - Female Voluntary Sterilization</b>		
<b>Inpatient</b>	100% of the allowed benefit per visit  No <b>copay</b> applies.	Not Covered
<b>Outpatient</b>	100% of the allowed benefit per visit  No <b>copay</b> applies.	Not Covered
<b>Family Planning Services - Female Contraceptives</b>		
<b>Female Contraceptive Devices</b> (associated office visit is payable in accordance with the type of expense incurred and the place where service is provided)	100% of the allowed benefit except Brand name covered at plan rate or same as office visit when provided in an office.	Not Covered.
<b>PLAN FEATURES</b>		
<b>NETWORK</b>		
<b>OUT-OF-NETWORK</b>		
<b>Vision Care</b>		
<b>Eye Examination-Medical</b> (Any service that deals with the medical health of the eye)	Payable in accordance with the type of expense incurred and the place where service is provided	Not Covered

<b><i>Routine Eye Examinations -</i></b> Including refraction (Any service that deals with correcting vision)	100% of the allowed benefit per visit No <b>copay</b> applies	Not Covered
Maximum Benefit per Calendar Year for participants over age 18	1 exam up to a maximum of \$45	Not Covered
Maximum Benefit per Calendar Year for participants age 18 and under	100% of the allowed benefit per visit No <b>copay</b> applies	Not Covered
<b><i>Vision Supplies</i></b> For participants over age 18	100% of the allowed benefit No <b>copay</b> applies	Not Covered
<b><i>Vision Supplies</i></b> For participants age 18 and under	100% of the allowed benefit No <b>copay</b> applies	Not Covered
Maximum Benefit for All Vision Supplies per Calendar Year for participants over age 18	\$200	Not Covered
Maximum Benefit for All Vision Supplies per Calendar Year for participants age 18 and under- <i>Frames, Lenses, Contacts (medically necessary only; contacts in lieu of frames/ lenses)</i>	100% of allowed benefit	Not Covered
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b><i>Physician Services</i></b>		
<b><i>Office Visits to Primary Care Physician</i></b> Office visits (non-surgical) to non- specialist	\$15 visit <b>copay</b> then the plan pays 100% of the allowed benefit	Not Covered
<b><i>Specialist Office Visits</i></b>	\$30 visit <b>copay</b> then the plan pays 100% of the allowed benefit	Not Covered
<b><i>Walk-In Clinics Non-Emergency Visit</i></b>	\$15 visit <b>copay</b> then the plan pays 100% of the allowed benefit	Not Covered

<b>Physician Office Visits - Surgery</b>		
<b>Physician</b>	100% of the allowed benefit per visit	Not Covered
<b>Specialist</b>	100% of the allowed benefit per visit	Not Covered
<b>Physician Services for Inpatient Facility and Hospital Visits</b>		
<b>Administration of Anesthesia</b> (paid based on facility not anesthesiologist)	100% of the allowed benefit per service	Not Covered
<b>Allergy Injections</b>	100% of the allowed benefit per visit	Not Covered
<b>Immunizations</b> (when not part of the physical exam) <i>immunizations for travel are excluded</i>	100% of the allowed benefit per visit	Not Covered
<b>PLAN FEATURES</b>	<b>NETWORK</b>	<b>OUT-OF-NETWORK</b>
<b>Emergency Medical Services</b>		
<b>Hospital Emergency Facility and Physician</b>	\$75 <b>copay</b> per visit then the plan pays 100% of the allowed benefit per visit  \$75 <b>copay</b> per visit then the plan pays 100% of the allowed benefit for emergency physician services	Paid same as Network benefits  <i>*See Important note below</i>
<b>*Important Note:</b> Please note that as these providers are not Network Providers and do not have a contract with <b>Aetna</b> , the provider may not accept payment of your cost share as payment in full. You may receive a bill for the difference between the amount billed by the provider and the amount paid by this Plan. If the Emergency Room Facility or <b>physician</b> bills you for an amount above your cost share, you are <b>not</b> responsible for paying that amount. Please send <b>Aetna</b> the bill at the address listed on the back of your member ID card and <b>Aetna</b> will resolve any payment dispute with the provider over that amount. Make sure your member ID number is on the bill.		
<b>Non-Emergency Care in a Hospital Emergency Room</b>	\$75 <b>copay</b> per visit then the plan pays 50% of the allowed benefit per visit  \$75 <b>copay</b> per visit then the plan pays 50% of the allowed benefit for emergency physician services	Not Covered

**Important Notice:**

A separate **hospital** emergency room **copay** applies for each visit to an emergency room for emergency care. If you are admitted to a **hospital** as an inpatient immediately following a visit to an emergency room, your **copay** is waived.

***Urgent Care Services***

<b><i>Urgent Medical Care</i></b> (at a non-hospital free standing facility)	\$30 <b>copay</b> per visit then the plan pays 100% of the allowed benefit	Not Applicable
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<b><i>Urgent Medical Care</i></b> (from other than a non-hospital free standing facility)	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.	Refer to <i>Emergency Medical Services</i> and <i>Physician Services</i> above.
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**PLAN FEATURES****NETWORK****OUT-OF-NETWORK*****Outpatient Diagnostic and Preoperative Testing******Complex Imaging Services***

<b><i>Complex Imaging</i></b> Precert required	100% of the allowed benefit per test	Not Covered
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***Diagnostic Laboratory Testing***

	100% of the allowed benefit per procedure	Not Covered
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***Diagnostic X-Rays***

<b><i>Diagnostic X-Rays (except Complex Imaging Services)</i></b>	100% of the allowed benefit per procedure	Not Covered
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**PLAN FEATURES****NETWORK****OUT-OF-NETWORK*****Outpatient Surgery***

<b><i>Outpatient Surgery</i></b>	100% of the allowed benefit per surgical procedure	Not Covered
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**PLAN FEATURES****NETWORK****OUT-OF-NETWORK*****Inpatient Facility Expenses***

<b><i>Birthing Center</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
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<b><i>Hospital Facility Expenses</i></b>		
Room and Board (including maternity)	100% of the allowed benefit per admission	Not Covered
Other than Room and Board	100% of the allowed benefit per admission	Not Covered
<b><i>Skilled Nursing Inpatient Facility</i></b>		
	100% of the allowed benefit per admission	Not Covered
Maximum Days per Calendar Year	180 days	Not Covered
<b>PLAN FEATURES NETWORK OUT-OF-NETWORK</b>		
<b><i>Specialty Benefits</i></b>		
<b><i>Home Health Care(Outpatient)</i></b>	100% of the allowed benefit per visit	Not Covered
Maximum Visits per Calendar Year	120 visits	Not Covered
<b><i>Private Duty Nursing (Outpatient)</i></b>	100% of the allowed benefit per visit	Not Covered
Maximum Visits per Calendar Year	Unlimited	Not Covered
<b><i>Hospice Benefits</i></b>		
<b><i>Hospice Care –Facility Expenses</i></b> (Room & Board)	100% of the allowed benefit per admission	Not Covered
<b><i>Hospice Care – Other Expenses during a stay</i></b>	100% of the allowed benefit per admission	Not Covered
Maximum Benefit per lifetime	Unlimited days	Not Covered
<b><i>Hospice Outpatient Visits</i></b>	100% of the allowed benefit per visit	Not Covered
<b>PLAN FEATURES NETWORK OUT-OF-NETWORK</b>		
<b><i>Infertility Treatment</i></b>		
<b><i>Basic Infertility Expenses</i></b> Coverage is for the diagnosis and treatment of the underlying medical condition causing the infertility only.	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

<b><i>Comprehensive Infertility Expenses</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
Artificial Insemination Maximum Benefit	3 attempts per live birth	Not Covered
Advanced Reproductive Technology (ART) Expenses	3 attempts per live birth	Not Covered
<b>PLAN FEATURES NETWORK OUT-OF-NETWORK</b>		
<b><i>Inpatient Treatment of Mental Disorders</i></b>		
<b><i>Hospital Facility Expenses</i></b>		
Room and Board	100% of the allowed benefit per admission	Not Covered
Other than Room and Board	100% of the allowed benefit per admission	Not Covered
Physician Services	100% of the allowed benefit per admission	Not Covered
<b><i>Inpatient Residential Treatment Facility Expenses</i></b>	100% of the allowed benefit per admission	Not Covered
<b><i>Inpatient Residential Treatment Facility Expenses Physician Services</i></b>	100% of the allowed benefit per visit	Not Covered
<b><i>Outpatient Treatment Of Mental Disorders</i></b>		
<b><i>Outpatient Services</i></b>	\$15 per visit copay then the plan pays 100% of the allowed benefit	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Inpatient Treatment of Substance Abuse</i></b>		
<b><i>Hospital Facility Expenses</i></b>		
Room and Board	100% of the allowed benefit per admission	Not Covered
Other than Room and Board	100% of the allowed benefit per admission	Not Covered
Physician Services	100% of the allowed benefit per admission	Not Covered
<b><i>Inpatient Residential Treatment Facility Expenses</i></b>	100% of the allowed benefit per admission	Not Covered
<b><i>Inpatient Residential Treatment Facility Expenses Physician Services</i></b>	100% of the allowed benefit per visit	Not Covered
<b><i>Outpatient Treatment of Substance Abuse</i></b>		
<b><i>Outpatient Services</i></b>	\$15 per visit copay then the plan pays 100% of the allowed benefit	Not Covered
PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Obesity Treatment Non Surgical</i></b>		
<b><i>Outpatient Obesity Treatment (non surgical)</i></b>	100% of the allowed benefit per visit	Not Covered
<b><i>Inpatient Morbid Obesity Surgery (includes Surgical procedure and Acute Hospital Services)</i></b>	100% of the allowed benefit per admission	Not Covered
<b><i>Outpatient Morbid Obesity Surgery</i></b>	100% of the allowed benefit per service	Not Covered
Maximum Benefit Morbid Obesity Surgery (Inpatient and Outpatient)	Unlimited	Not Covered

PLAN FEATURES	NETWORK (IOE Facility)	NETWORK (Non-IOE Facility)	OUT-OF-NETWORK
<b><i>Transplant Services Facility and Non-Facility Expenses</i></b>			
<b><i>Transplant Facility Expenses</i></b>	100% of the allowed benefit per admission	Not Covered	Not Covered
<b><i>Transplant Physician Services</i></b> (including office visits)	Payable in accordance with the type of expense incurred and the place where service is provided	Not Covered	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Other Covered Health Expenses</i></b>		
<b><i>Acupuncture</i></b> (When administered by a Licensed Acupuncturist for pain management only)	100% of the allowed benefit per visit	Not Covered
<b><i>Ground, Air or Water Ambulance</i></b>	100% of the allowed benefit	Not Covered
<b><i>Diabetic Equipment, Supplies and Education</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b><i>Durable Medical and Surgical Equipment</i></b>	100% of the allowed benefit per item	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Oral and Maxillofacial Treatment (Mouth, Jaws and Teeth)</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b><i>Prosthetic Devices</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b><i>Nutritional Support</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Outpatient Therapies</i></b>		
<b><i>Chemotherapy</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b><i>Infusion Therapy</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered
<b><i>Radiation Therapy</i></b>	Payable in accordance with the type of expense incurred and the place where service is provided.	Not Covered

PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Short Term Outpatient Rehabilitation Therapies</i></b>		
<b><i>Outpatient Physical, Occupational, and Speech Therapy combined</i></b>	\$30 per visit <b>copay</b> then the plan pays 100% of the allowed benefit	Not Covered
<b><i>Services Rendered by Chiropractor</i></b>	100% of the allowed benefit per visit	

<b>Combined Physical, Occupational and Speech Therapy Maximum visits per Calendar Year</b>	50 visits	Not Covered
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PLAN FEATURES	NETWORK	OUT-OF-NETWORK
<b><i>Spinal Manipulation</i></b>		
	100% of the allowed benefit per visit	Not Covered

## Expense Provisions

**The following provisions apply to your health expense plan.**

This section describes cost sharing features, benefit maximums and other important provisions that apply to your Plan. The specific cost sharing features and the applicable dollar amounts or benefit percentages are contained in the attached health expense sections of this *Schedule of Benefits*.

This *Schedule of Benefits* replaces any *Schedule of Benefits* previously in effect under your plan of health benefits.

**KEEP THIS SCHEDULE OF BENEFITS WITH YOUR BOOKLET.**

## Copayments and Payment Provisions

### Copayment, Copay

This is a specified dollar amount or percentage of the **negotiated charge** required to be paid by you at the time you receive a covered service from a **network provider**. It represents a portion of the applicable expense.

### Copayment Maximum Out-of-Pocket Limit

Your plan has a **copayment maximum out-of-pocket limit**. Your **copays** apply to the copayment **maximum out-of-pocket limit**. Once you satisfy the maximum amount the plan will pay 100% of **covered expenses** that apply toward the limit for the rest of the Calendar Year.

## Payment Provisions

### Coinsurance

This is the percentage of your **covered expenses** that the plan pays and the percentage of **covered expenses** that you pay. The percentage that the plan pays is referred to as the “Plan Coinsurance”. The coinsurance may vary by the type of expense. Refer to your *Schedule of Benefits* for coinsurance amounts for each covered benefit.

## General

This Schedule of Benefits replaces any similar Schedule of Benefits previously in effect under your plan of benefits. Requests for coverage other than that to which you are entitled in accordance with this Schedule of Benefits cannot be accepted. This Schedule is part of your Booklet and should be kept with your Booklet.